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ABSTRACT

The word "stress" all too often describes the emotional state of a parent after the premature birth of a high risk infant. Research studies indicate specific reasons for parental stress in the context and settings associated with the premature birth of a child. Such reasons include lack of preparation for the early birth, the immature appearance and behavior of the infant, the grieving process in the parents, and the unfamiliar and frightening atmosphere of the neonatal intensive care unit. In this paper strategies for alleviation of these parental stress factors are proposed for utilization by the professional health care team.
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ABSTRACT

STRESS FACTORS AND THEIR ALLEVIATION IN
PARENTS OF HIGH RISK PRETERM INFANTS

Dr. Barbara Lowenthal

The word "stress" all too often describes the emotional state of a parent after the premature birth of a high risk infant. Research studies indicate specific reasons for this stress such as the following: lack of preparation for the early birth, the immature appearance and behavior of the infant, the grieving process in the parents, and the unfamiliar and frightening atmosphere of the neonatal intensive care unit. Strategies for alleviation of these parental stress factors are proposed for utilization by the professional health care team.

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STRESS FACTORS AND THEIR ALLEVIATION IN PARENTS OF HIGH RISK PRETERM INFANTS

The word "stress" all too often describes the emotional state of a parent after the birth of a preterm high risk infant. This article will review research studies which suggest reasons for this emotional state as well as proposing strategies that may help in stress reduction. These strategies can be utilized by professionals in their supportive relationships with parents of premature babies. The first source of stress for these parents could be related to their lack of preparation for the early labor and delivery. Several studies (Kennedy, 1973; Kopf and McFadden, 1974; Slade, Redl and Manguten, 1977; Brazeton, 1982) have indicated that many mothers and fathers feel anxious and guilty as well as fearing something they did or did not do during the pregnancy may have affected the baby and produced the immaturity.

Additional stress is often created by the neonatal intensive care environment (Johnson, 1983); it is often uncomfortable, noisy, and impersonal, and parents are unprepared for it. The least prepared the parents are, the more anxiety they feel. The immediate crisis of the first twenty-four hours is whether their infant will live. If he/she survives, added stress to the mother and father involves the immature behavior of the baby. Unlike the full term infant, the premie has undeveloped reflexes and bahavior. For example, the preterm baby may not grasp as strongly or smile as readily as the full term new born. Parents become concerned and may misinterpret this lack of response as rejection of them by the

infant. Also, the premature at risk infant often has a weak sucking reflex which again could be misinterpreted by the mother as a reflection on her ability to nurse. In addition, the appearance of the premie is different from that of a full term baby as he/she appears small, fragile, undeveloped, and less attractive.

The infant's cry pattern could be aversive for his parents as the typical cry of a premature baby is higher pitched than that of the full term infant; this more irritating cry could result in greater anxiety and annoyance in the parents which in turn leads to less interest in interaction and attachment to their child (Frodi, 1978). Another disturbing factor is that there may be an increase of feeding problems because of the premie's low birth-weight. He needs to be fed more often, and special techniques may be necessary; both of these factors place greater demands upon parents as well as making caregiving a less satisfying task. As Goldberg (1979) reported in her study, premature infants spend less time alert, are more difficult to keep in alert states, are less responsive to sights and sounds than term babies, and provide fewer distinctive clues to guide parental treatment. In view of these behavioral characteristics, it is not surprising that many studies have reported that parents have to work harder when interacting with a premie (Brown and Bakeman, 1980; Frodi, 1978; Parke and Tinsley, 1982) which contributes to parental exhaustion and stress.

Other major problems are the feelings of grief and depression that parents generally have following a premature birth of a handicapped child (Brazelton, 1982). The mother and/or father grieve not only over the loss of their "normal" child but also over

the loss of opportunity to be a "normal parent." They miss showing the baby to their family and friends, not being able to breast-feed immediately, and other processes associated with normal parenting. Exhaustion is a common feeling as the parents attempt to handle their new stresses, visit the infant, take care of the rest of the family, and perhaps return to work. Difficulties can also arise from their disappointment over unfilled expectations. The husband or wife may feel "let down" by one another or by their at risk infant and blame each other for their disappointments.

Brazelton (1982) proposes that there is a system of five stages parents go thru before they are finally able to make an attachment to their premature baby. These five stages help pinpoint when parents are becoming less defensive and better adjusted. The first stage occurs when parents can only talk about their baby in terms of his/her chemical balance and whether it is in equilibrium or not. This then is their initial way of relating to their infant. The second stage begins when the parents observe reflex behaviors in the baby but these are always seen in relation to somebody else. For example, the mother or father may say, "If the nurse touches the baby, he startles." The third stage develops when the parents notice more human behaviors, but they are still seen in relation to somebody else and not themselves. The parents may talk about the baby and touch him or her, but no eye contact is established. They see responsive behavior only in terms of the nurse or doctor. A parental statement in this stage could be, "When the doctor talks to the baby, he/she alerts to his voice." The fourth stage is achieved when parents can

see responsive behavior in relation to themselves such as, "If we talk to our infant, she turns to us." It is "our" baby by now. The fifth stage occurs when parents can pick up the child and start the process of caretaking; thus, they can relate behaviorally as well as verbally to their infant. These stages take time, and parents must get over their acute grieving before they can master each of these stages.

How can we help these parents progress through these stages as well as reduce the stress of a premature at risk birth? The following strategies can be utilized by professionals on an interdisciplinary team in the premature nursery:

1. Avoid false rescuing behaviors. Giving false hope or empty encouragement will not help parents in this situation nor does it alleviate grief and pain. Such ineffective rescuing statements include: "Your child will turn out fine- it is just going to take time." Unfortunately, this may be altogether false, and it is not proper for the professional to offer this encouragement if it is inappropriate to do so.

2. Increase parent-infant interaction. Increased interaction, which does not overload the sensory system of the baby, allows the mother and father to perform their normal parenting roles and allays their anxieties and fears about the infant and their own caretaking abilities. Some studies (Winnicot, 1971; Field, 1977; Travarthen, 1977) have indicated that this interaction should be in the form of imitating or mirroring the baby's gestures and movements which increases his response to the parents and lengthens his gaze.

3. Encourage appropriate role shifts. When the parents'

roles are complementary, they can help each other in the crisis situation of premature birth. However, when their roles are in conflict such as when one or the other assumes all the responsibilities for visiting and caretaking, the crisis can escalate.

4. Give parents more control in the neonatal high risk nursery. A common complaint of parents is their lack of control in the hospital situation. Professionals can give more control and thus alleviate some of parental stress in such matters as visiting times and feeding times; these can be decided upon in consultation with parents as well as medical personnel.

5. Avoid assumptions of what is best for parents. Each parent reacts uniquely to the crisis of premature birth. A useful suggestion for one mother might be resented by another. A statement that is comforting to one father may be painful to another. Sensitivity and empathy for differences in parents as well as flexibility in providing for their needs are beneficial qualities in any professional associated with the high risk nursery.

6. Increase the parents' pride in their infant. This is an essential part of the professional's role. Parents can take pride in their baby when his/her strengths and positive behaviors are pointed out to them.

7. Encourage parents to form support groups with other parents of high risk preterm infants. Parents find much relief and solace in being able to talk out their feelings and fears to other parents who are facing the same crisis.

Other strategies that have been utilized to alleviate stress in parents of preterm children concern visiting and caretaking arrangements in the neonatal unit. One suggestion, which resulted

from a study done by Klaus and Kennell (1981), is the practice of rooming-in. Mothers of premature infants lived in a room adjoining the premature nursery. Each feeding time, they fed and took care of their babies. The mothers also ate together as a group so they could share feelings and experiences for mutual support. Another innovative practice is that of nesting in which parents are permitted to live in with their infants before discharge and are expected to perform all caregiving routines. Nesting seems to improve parents' confidence in their caretaking skills and allays their fears. Another new procedure initiated by Klaus and Kennell (1981) is to allow the premature infant to visit his/her mother in the hospital. Instead of bringing the mother in the neonatal intensive care unit with its frightening sounds, strange equipment, and unfamiliar faces, the baby is brought to the mother's room in the maternity division of the hospital. In this way, the parent has an opportunity to become acquainted with her premature newborn under circumstances experienced by mothers of full term infants. The babies, who are relatively healthy and weigh between 1500 and 2000 grams, are monitored by the nurse while in their mothers' rooms for any sign of respiratory or cardiac distress.

These new procedures and the strategies already described are suggestions that can be utilized by the health care professional team in the high risk nursery in order to reduce and alleviate some of the worrisome stress experienced by parents of at risk premature infants.

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